FOR OHF USE

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2001
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2001)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0036053

Facility Name: Care Center of Abingdon

Address: 2000 West Martin (Number) Abingdon (City) 61410 (Zip Code)

County: Knox

Telephone Number: (309) 343-4556 **Fax #** (309) 343-0981

IDPA ID Number: 37-1184958001

Date of Initial License for Current Owners: 03/01/87

Type of Ownership:

	VOLUNTARY,NON-PROFIT	x	PROPRIETARY		GOVERNMENTAL
	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code			Corporation		Other
		x	"Sub-S" Corp.		
			Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: Ron Wilson **Telephone Number:** (309) 343-1550

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 1/1/01 to 12/31/01 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider

(Signed) _____ (Date)
(Type or Print Name) Ron Wilson
(Title) Chief Financial Officer

Paid Preparer

(Signed) See Independent Accountant's Report (Date)
(Print Name and Title) McGladrey & Pullen, LLP
(Firm Name & Address) 117 East Main, Suite 210, P.O. Box 1070, Galesburg, Illinois 61402
(Telephone) (309) 342-1175 Fax # (309) 342-7816

MAIL TO: OFFICE OF HEALTH FINANCE
ILLINOIS DEPARTMENT OF PUBLIC AID
201 S. Grand Avenue East
Springfield, IL 62763-0001 Phone # (217) 782-1630

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Care Center of Abingdon # 0036053 Report Period Beginning: 1/1/01 Ending: 12/31/01

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds N/A

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	88	Skilled (SNF)	88	32,120	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	88	TOTALS	88	32,120	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Public Aid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	3,751	1,321	1,315	6,387	8
9	SNF/PED					9
10	ICF	7,502	3,979	0	11,481	10
11	ICF/DD					11
12	SC			0		12
13	DD 16 OR LESS					13
14	TOTALS	11,253	5,300	1,315	17,868	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 55.63%

D. How many bed-hold days during this year were paid by Public Aid?
6 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
None

F. Does the facility maintain a daily midnight census? Yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [ ] NO [x]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [x]

I. On what date did you start providing long term care at this location?
Date started 03/01/87

J. Was the facility purchased or leased after January 1, 1978?
YES [x] Date 02/07/86 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [x] NO [ ] If YES, enter number of beds certified 12 and days of care provided 1,315

Medicare Intermediary AdminaStar Federal Inc.

IV. ACCOUNTING BASIS

ACCRUAL [x] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [x] NO [ ]

Tax Year: 12/31/01 Fiscal Year: 12/31/01

* All facilities other than governmental must report on the accrual basis.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Care Center of Abingdon # 0036053 Report Period Beginning: 1/1/01 Ending: 12/31/01

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger Salary/Wage 1	Supplies 2	Other 3	Total 4	Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR OHF USE ONLY 9	10	
	A. General Services											
1	Dietary	126,028	7,868	6,600	140,496		140,496		140,496			1
2	Food Purchase		106,570		106,570		106,570	(6,586)	99,984			2
3	Housekeeping	56,087	10,885	250	67,222		67,222		67,222			3
4	Laundry	40,658	3,869		44,527		44,527		44,527			4
5	Heat and Other Utilities			65,595	65,595		65,595	176	65,771			5
6	Maintenance	18,070	9,561	14,568	42,199		42,199	253	42,452			6
7	Other (specify):*											7
8	**TOTAL General Services**	240,843	138,753	87,013	466,609		466,609	(6,157)	460,452			8
	B. Health Care and Programs											
9	Medical Director			12,000	12,000		12,000		12,000			9
10	Nursing and Medical Records	676,823	73,929	2,971	753,723		753,723		753,723			10
10a	Therapy			63,570	63,570		63,570		63,570			10a
11	Activities	42,830	944	315	44,089		44,089		44,089			11
12	Social Services	29,277		330	29,607		29,607		29,607			12
13	Nurse Aide Training											13
14	Program Transportation			702	702	552	1,254		1,254			14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	748,930	74,873	79,888	903,691	552	904,243		904,243			16
	C. General Administration											
17	Administrative	64,823			64,823		64,823	44,679	109,502			17
18	Directors Fees											18
19	Professional Services			91,650	91,650		91,650	(64,437)	27,213			19
20	Dues, Fees, Subscriptions & Promotions			30,628	30,628		30,628	(22,702)	7,926			20
21	Clerical & General Office Expenses	16,629	11,742	23,100	51,471		51,471	3,826	55,297			21
22	Employee Benefits & Payroll Taxes			207,934	207,934		207,934	7,115	215,049			22
23	Inservice Training & Education			225	225		225		225			23
24	Travel and Seminar			1,715	1,715		1,715	2,119	3,834			24
25	Other Admin. Staff Transportation			1,103	1,103	(552)	551	1,733	2,284			25
26	Insurance-Prop.Liab.Malpractice			42,716	42,716		42,716	127	42,843			26
27	Other (specify):* See Attached Sch VI			2,589	2,589		2,589	(2,589)				27
28	**TOTAL General Administration**	81,452	11,742	401,660	494,854	(552)	494,302	(30,129)	464,173			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	1,071,225	225,368	568,561	1,865,154		1,865,154	(36,286)	1,828,868			29

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.

SEE ACCOUNTANTS' COMPILATION REPORT

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number Care Center of Abingdon #0036053 Report Period Beginning: 1/1/01 Ending: 12/31/01

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4	5	6	7	8	9	10	
	D. Ownership											
30	Depreciation			18,650	18,650		18,650	81,208	99,858			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			8,809	8,809		8,809	(8,727)	82			32
33	Real Estate Taxes			51,195	51,195		51,195	156	51,351			33
34	Rent-Facility & Grounds			275,616	275,616		275,616	(273,499)	2,117			34
35	Rent-Equipment & Vehicles			2,411	2,411		2,411	355	2,766			35
36	Other (specify):* **Amortization**											36
37	**TOTAL Ownership**			356,681	356,681		356,681	(200,507)	156,174			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers			2,206	2,206		2,206		2,206			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops			3	3		3		3			41
42	Provider Participation Fee			48,180	48,180		48,180		48,180			42
43	Other (specify):*											43
44	**TOTAL Special Cost Centers**			50,389	50,389		50,389		50,389			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	1,071,225	225,368	975,631	2,272,224		2,272,224	(236,793)	2,035,431			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Care Center of Abingdon # 0036053 Report Period Beginning: 1/1/01 Ending: 12/31/01

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Reference	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(6,425)	2		4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	11,376	30		9
10	Interest and Other Investment Income		32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(161)	2		13
14	Non-Care Related Interest	(8,809)	32		14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(2,202)	27		24
25	Fund Raising, Advertising and Promotional	(20,570)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising	(2,139)	20		28
29	Other-Attach Schedule See Attached Schedule VII	(387)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (29,317)		$	30

OHF USE ONLY								
48		49		50		51		52

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense		31	33
34	Adjustments for Related Organization Costs (Schedule VII)	(207,476)		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (207,476)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (236,793)		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.		x	$		38
39						39
40	Gift and Coffee Shops		x			40
41	Barber and Beauty Shops		x			41
42	Laboratory and Radiology		x			42
43	Prescription Drugs		x			43
44	Exceptional Care Program		x			44
45	Other-Attach Schedule		x			45
46	Other-Attach Schedule		x			46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

SEE ACCOUNTANTS' COMPILATION REPORT

Care Center of Abingdon

ID# 0036053

Report Period Beginning: 1/1/01

Ending: 12/31/01

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1		$		1
2				2
3				3
4				4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total	0		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Care Center of Abingdon **#** 0036053 **Report Period Beginning:** 1/1/01 **Ending:** 12/31/01

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(6,586)	0	0	0	0	0	0	0	0	0	0	(6,586)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	0	0	0	0	0	0	0	0	0	0	0	0	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	(6,586)	0	0	0	0	0	0	0	0	0	0	(6,586)	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	Nurse Aide Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	0	0	0	0	0	0	0	0	0	0	0	0	16
	C. General Administration													
17	Administrative	0	0	0	0	0	0	0	0	0	0	0	0	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	(41)	0	0	0	0	0	0	0	0	0	(41)	19
20	Fees, Subscriptions & Promotions	(22,709)	0	0	0	0	0	0	0	0	0	0	(22,709)	20
21	Clerical & General Office Expenses	0	0	0	0	0	0	0	0	0	0	0	0	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	0	0	0	0	0	0	0	0	0	0	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	0	0	0	0	0	0	0	0	0	0	0	26
27	Other (specify):*	(2,202)	0	0	0	0	0	0	0	0	0	0	(2,202)	27
28	**TOTAL General Administration**	(24,911)	(41)	0	0	0	0	0	0	0	0	0	(24,952)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(31,497)	(41)	0	0	0	0	0	0	0	0	0	(31,538)	29

STATE OF ILLINOIS **Summary B**

Facility Name & ID Number **Care Center of Abingdon** **# 0036053** **Report Period Beginning:** **1/1/01** **Ending:** **12/31/01**

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	D. Ownership													
30	Depreciation	11,376	0	0	0	0	0	0	0	0	0	0	11,376	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(8,809)	0	0	0	0	0	0	0	0	0	0	(8,809)	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	(207,435)	0	0	0	0	0	0	0	0	0	(207,435)	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	**TOTAL Ownership**	2,567	(207,435)	0	0	0	0	0	0	0	0	0	(204,868)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	**TOTAL Special Cost Centers**	0	0	0	0	0	0	0	0	0	0	0	0	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(28,930)	(207,476)	0	0	0	0	0	0	0	0	0	(236,406)	45

Facility Name & ID Number Care Center of Abingdon # 0036053 Report Period Beginning: 1/1/01 Ending: 12/31/01

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
Midwest Healthcare, Inc.	100%	See Attached Schedule I		RFMS, Inc.	Galesburg	Admin. Svcs.
(100% owned by Don Fike)						
				Donald E. Fike	Galesburg	Lessor

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [x] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

	1 Schedule V	2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V			$			$	$	1
2	V	34	Facility Rental	275,616	Donald E. Fike	100.00%	68,181	(207,435)	2
3	V								3
4	V								4
5	V	19	Administrative Services	66,000	RFMS, Inc.	None	65,959	(41)	5
6	V				(100% owned by Don Fike)				6
7	V								7
8	V								8
9	V				See Attached Schedules III and IV				9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$ 341,616			$ 134,140	$ * (207,476)	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Care Center of Abingdon # 0036053 Report Period Beginning: 1/1/01 Ending: 12/31/01

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1									$		1
2	Don Fike	President	Management	100.00	See Attached	>40	100.00	Salary	4,705	17-7	2
3					Schedule III			Benefits	317	22-7	3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$ 5,022		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Care Center of Abingdon # 0036053 Report Period Beginning: 1/1/01 Ending: 12/31/01

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [ ] NO [X]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Care Center of Abingdon # 0036053 Report Period Beginning: 1/1/01 Ending: 12/31/01

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related Long-Term											
1							$	$			$	1
2												2
3												3
4												4
5												5
	Working Capital											
6	Interest Income Adjustment			From page 5, line 10								6
7	Miscellaneous Vendors		x	Miscellaneous operating								7
8	Home Office Allocation Adj.			See Attached Schedule III							82	8
9	TOTAL Facility Related						$	$			$ 82	9
	B. Non-Facility Related*											
10												10
11	Don Fike (owner)	x		Working Capital			405,000	405,000			8,809	11
12	Non-allowable interest										(8,809)	12
13												13
14	TOTAL Non-Facility Related						$ 405,000	$ 405,000			$	14
15	TOTALS (line 9+line14)						$ 405,000	$ 405,000			$ 82	15

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)

Facility Name & ID Number Care Center of Abingdon # 0036053 Report Period Beginning: 1/1/01 Ending: 12/31/01

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.

1. Real Estate Tax accrual used on 2000 report.	$	43,380	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	$	46,775	2
3. Under or (over) accrual (line 2 minus line 1).	$	3,395	3
4. Real Estate Tax accrual used for 2001 report. (Detail and explain your calculation of this accrual on the lines below.)	$	47,800	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**	$		5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For 19 Tax Year. (Attach a copy of the real estate tax appeal board's decision.)**	$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.	$	51,195	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	1996	47,481	8
	1997	47,083	9
	1998	45,022	10
	1999	43,373	11
	2000	45,525	12

Real estate tax accrual is based on estimated tax expense. The lessee, by terms of the lease agreement, is required to pay the applicable real estate taxes.

	FOR OHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2000	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.**
   This denial must be no more than four years old at the time the cost report is filed.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2000 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2000 real estate tax costs, as well as copies of your real estate tax bills for calendar 2000.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2000 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2001 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Office of Health Finance at (217) 782-1630.

2000 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Care Center of Abingdon COUNTY Knox

FACILITY IDPH LICENSE NUMBER 0036053

CONTACT PERSON REGARDING THIS REPORT Ron Wilson

TELEPHONE (309) 343-1550 FAX #: (309) 343-2857

A. **Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2000 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2000.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	1332455017	Fike Don & Marie	$ 45,525.00	$ 45,525.00
2.			$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 45,525.00	$ 45,525.00

B. **Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? YES X NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. **Tax Bills**

Attach a copy of the 2000 tax bills which were listed in Section A to this statement. Be sure to use the 2000 tax bill which is normally paid during 2001.

Facility Name & ID Number Care Center of Abingdon # 0036053 Report Period Beginning: 1/1/01 Ending: 12/31/01

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 24,366 B. General Construction Type: Exterior Brick Frame Wood Number of Stories 1

C. Does the Operating Entity? [ ] (a) Own the Facility [x] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? [x] (a) Own the Equipment [x] (b) Rent equipment from a Related Organization. [ ] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

None

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [x] NO
If so, please complete the following:

1. Total Amount Incurred: N/A
2. Number of Years Over Which it is Being Amortized: N/A
3. Current Period Amortization: N/A
4. Dates Incurred: N/A

Nature of Costs: N/A
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	Facility	5.85 Acres	1986	$ 33,333	1
2					2
3	TOTALS			$ 33,333	3

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Care Center of Abingdon # 0036053 Report Period Beginning: 1/1/01 Ending: 12/31/01

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	74			1986	$ 999,667	$ 39,987	30	$ 39,987	$	$ 645,790	4
5	14			1993	619,929	15,896	39	15,896		129,817	5
6											6
7											7
8											8
	Improvement Type**										
9	Total improvements by year constructed:										9
10	1987			1987	86,942	4,603	5-19	4,603		73,888	10
11	1988			1988	8,021	535	15	535		7,089	11
12	1989			1989	6,417	169	10-31	169		3,234	12
13	1990			1990	40,719	1,293	5-20	1,649	356	26,296	13
14	1991			1991	1,975		15	132	132	1,375	14
15	1992			1992	7,058	224	10	672	448	6,463	15
16	1993			1993	78,808	2,021	7-20	3,768	1,747	35,154	16
17	1994			1994	3,355	197	15-40	186	(11)	1,437	17
18	1995			1995	31,300	1,848	20	1,565	(283)	10,042	18
19	1996			1996	55,351	2,980	20	2,768	(212)	14,777	19
20	1997			1997							20
21	Detailed improvements for years 1998 - 2001:										21
22	Center dome roof			1999	28,389	901	10	2,839	1,938	7,807	22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36											36

*Total beds on this schedule must agree with page 2.

See Page 12A, Line 70 for total

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Care Center of Abingdon # 0036053 Report Period Beginning: 1/1/01 Ending: 12/31/01

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37			$	$		$	$	$	37
38									38
39									39
40									40
41									41
42									42
43									43
44									44
45									45
46									46
47									47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$ 1,967,931	$ 70,654		$ 74,769	$ 4,115	$ 963,169	70

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Care Center of Abingdon # 0036053 Report Period Beginning: 1/1/01 Ending: 12/31/01

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 436,856	$ 14,968	$ 22,228	$ 7,260	5-15 yrs	$ 386,889	71
72	Current Year Purchases	12,935	1,209	1,210	1	5-10 yrs	1,210	72
73	Fully Depreciated Assets							73
74	Indirect Costs Allocated (See Attached Schedule III)		1,651	1,651				74
75	TOTALS	$ 449,791	$ 17,828	$ 25,089	$ 7,261		$ 388,099	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	Patient Care	89 Ford Aerostar	1993	$ 4,298	$	$	$	5 yrs	$ 4,298	76
77										77
78										78
79										79
80	TOTALS			$ 4,298	$	$	$		$ 4,298	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 2,455,353	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 88,482	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 99,858	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 11,376	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 1,355,566	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		$	$	$	86
87					87
88					88
89					89
90					90
91	TOTALS	$	$	$	91

G. Construction-in-Progress

	Description	Cost	
92		$	92
93			93
94			94
95		$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: Donald E. Fike

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions. [X] YES [ ] NO

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$ See Attached			3
4	Additions				Schedule IV -			4
5					Related Party			5
6					Lease			6
7	TOTAL				$ **			7

8. List separately any amortization of lease expense included on page 4, line 34.
This amount was calculated by dividing the total amount to be amortized
by the length of the lease .

9. Option to Buy: [ ] YES [ ] NO Terms: *

10. Effective dates of current rental agreement:
Beginning
Ending

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2002	$
13.	/2003	$
14.	/2004	$

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? [ ] YES [ ] NO

16. Rental Amount for movable equipment: $ Description:
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			$	$	17
18					18
19					19
20					20
21	TOTAL		$	$	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

Facility Name & ID Number Care Center of Abingdon # 0036053 Report Period Beginning: 1/1/01 Ending: 12/31/01

XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD? [ ] YES [x] NO

If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - COMMUNITY COLLEGE [ ]
   - HOURS PER AIDE

3. CLINICAL PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - HOURS PER AIDE

All nurse aides have met training requirements.

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	$	$	$	$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	Nurse Aide Competency Tests				
9	TOTALS	$	$	$	$
10	SUM OF line 9, col. 1 and 2 (e)	$			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

$ None

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.
(e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

SEE ACCOUNTANTS' COMPILATION REPORT

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

	1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff Units of Service	Staff Cost	Outside Practitioner (other than consultant) Units	Outside Practitioner (other than consultant) Cost	Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist		hrs	$		$	$		$	1
2	Licensed Speech and Language Development Therapist		hrs							2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs							4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy		# of prescrpts							9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify):									13
14	TOTAL			$		$	$		$	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Care Center of Abingdon # 0036053 **Report Period Beginning:** 1/1/01 **Ending:** 12/31/01

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 12/31/01 (last day of reporting year)

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 75,624	$ 156,879	1
2	Cash-Patient Deposits	1,296	1,296	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	313,800	739,595	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance		27,491	6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)		1,574,571	8
9	Other(specify): See Attached Schedule VIII			9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 390,720	$ 2,499,832	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments		104,078	12
13	Land		3,333	13
14	Buildings, at Historical Cost		1,619,596	14
15	Leasehold Improvements, at Historical Cost	246,955	483,145	15
16	Equipment, at Historical Cost	243,850	1,076,380	16
17	Accumulated Depreciation (book methods)	(293,728)	(1,953,176)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): Loan Financing Costs			23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 197,077	$ 1,333,356	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 587,797	$ 3,833,188	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 69,706	$ 103,996	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	1,296	1,296	28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	87,369	213,321	30
31	Accrued Taxes Payable (excluding real estate taxes)	2,738	2,738	31
32	Accrued Real Estate Taxes(Sch.IX-B)	47,800	53,686	32
33	Accrued Interest Payable	8,809	8,809	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	Related Party Loan	405,000	405,000	36
37	Other Accrued Liabilities	65,000	65,000	37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 687,718	$ 853,846	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44	Resident Security Deposits			44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 687,718	$ 853,846	46
47	**TOTAL EQUITY(page 18, line 24)**	$ (99,921)	$ 2,979,342	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 587,797	$ 3,833,188	48

SEE ACCOUNTANTS' COMPILATION REPORT

***(See instructions.)**

Facility Name & ID Number Care Center of Abingdon # 0036053 Report Period Beginning: 1/1/01 Ending: 12/31/01

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 316,980	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 316,980	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(416,901)	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	( )	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ (416,901)	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ (99,921)	24 *

*** This must agree with page 17, line 47.**

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Care Center of Abingdon # 0036053 Report Period Beginning: 1/1/01 Ending: 12/31/01

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 1,810,137	1
2	Discounts and Allowances for all Levels	( )	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 1,810,137	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	31,080	6
7	Oxygen	4,000	7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 35,080	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care	2,374	13
14	Non-Patient Meals	6,425	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 8,799	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	414	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 414	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Activity Fund Income		28
28a	Durable Medical Equipment	855	28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 855	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 1,855,285	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	466,609	31
32	Health Care	903,691	32
33	General Administration	494,854	33
	B. Capital Expense		
34	Ownership	356,681	34
	C. Ancillary Expense		
35	Special Cost Centers	2,209	35
36	Provider Participation Fee	48,180	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 2,272,224	40
41	**Income before Income Taxes (line 30 minus line 40)****	(416,939)	41
42	**Income Taxes**	38	42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (416,901)	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return? No If not, please attach a reconciliation.** See Attached Schedule V

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.** SEE ACCOUNTANTS' COMPILATION REPORT

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.

Facility Name & ID Number Care Center of Abingdon # 0036053 Report Period Beginning: 1/1/01 Ending: 12/31/01

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	1,955	2,080	$ 42,527	$ 20.45	1
2	Assistant Director of Nursing			0		2
3	Registered Nurses	7,402	7,875	109,225	13.87	3
4	Licensed Practical Nurses	10,243	10,897	121,719	11.17	4
5	Nurse Aides & Orderlies	43,206	45,964	369,093	8.03	5
6	Nurse Aide Trainees					6
7	Licensed Therapist			0		7
8	Rehab/Therapy Aides			0		8
9	Activity Director	1,895	2,016	20,723	10.28	9
10	Activity Assistants	2,948	3,136	22,107	7.05	10
11	Social Service Workers	2,560	2,723	29,277	10.75	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	17,219	18,318	126,028	6.88	15
16	Dishwashers					16
17	Maintenance Workers	1,633	1,738	18,070	10.40	17
18	Housekeepers	9,415	10,016	56,087	5.60	18
19	Laundry	5,925	6,304	40,658	6.45	19
20	Administrator	1,955	2,080	47,379	22.78	20
21	Assistant Administrator	1,491	1,586	17,444	11.00	21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	1,737	1,848	16,629	9.00	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	516	549	6,039	11.00	31
32	Other Health C: Supervisors	2,040	2,171	28,220	13.00	32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	112,140	119,301	$ 1,071,225 *	$ 8.98	34

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	***	$ 6,600	1-3	35
36	Medical Director	***	12,000	9-3	36
37	Medical Records Consultant	***	1,531	10-3	37
38	Nurse Consultant	***		10-3	38
39	Pharmacist Consultant	***	1,440	10-3	39
40	Physical Therapy Consultant	***	37,080	10a-3	40
41	Occupational Therapy Consultant	***	19,304	10a-3	41
42	Respiratory Therapy Consultant	***		10a-3	42
43	Speech Therapy Consultant	***	7,186	10a-3	43
44	Activity Consultant	***		11-3	44
45	Social Service Consultant	***	330	12-3	45
46	Other(specify) Dental Consultant	***	0	10-3	46
47	Psychological Consultant	***		10-3	47
48	***=Monthly Fee Arrangement				48
49	TOTAL (lines 35 - 48)		$ 85,471		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses		$		50
51	Licensed Practical Nurses				51
52	Nurse Aides				52
53	TOTAL (lines 50 - 52)		$		53

SEE ACCOUNTANTS' COMPILATION REPORT

* This total must agree with page 4, column 1, line 45. ** See instructions.

Facility Name & ID Number Care Center of Abingdon # 0036053 Report Period Beginning: 1/1/01 Ending: 12/31/01

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
			$
Marge Mahnesmith	Administrator	None	47,379
Alice Becker	Asst. Admin.	None	17,444
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 64,823

B. Administrative - Other

Description	Amount
	$
TOTAL (agree to Schedule V, line 17, col. 3)	$
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
		$
RFMS, Inc.	Administrative Services	66,000
McGladrey & Pullen, LLP	Accounting Services	15,155
Systematic Management	Collections Consultant	10,412
FR&R Healthcare Consulting		83
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $2500 attach copy of invoices.)		$ 91,650

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 33,330
Unemployment Compensation Insurance	11,380
FICA Taxes	81,002
Employee Health Insurance	69,359
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
401(k) Plan Contributions	9,429
Other Employment Benefits	1,674
Employee Appreciation	1,760
Indirect Costs - See Attached Sch. III	7,115
TOTAL (agree to Schedule V, line 22, col.8)	$ 215,049

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
		$
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$ 0
Advertising: Employee Recruitment	1,684
Health Care Worker Background Check	624
(Indicate # of checks performed 52)	
IHCA Dues	4,431
Subscriptions & Fees	1,052
Other Licenses	128
Advertising - Promotional	20,570
Advertising - Yellow Pages	2,139
Indirect Costs - See Attached Sch III	7
Less: Public Relations Expense	( )
Non-allowable advertising	(20,570)
Yellow page advertising	(2,139)
TOTAL (agree to Sch. V, line 20, col. 8)	$ 7,926

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Staff use of personal vehicle on facility	
business and meals (under $250 per	637
travel voucher)	
Seminar Expense	1,078
Indirect Costs - See Attached Sch. III	2,119
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 3,834

* Attach copy of IMRF notifications

**See instructions.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Care Center of Abingdon # 0036053 Report Period Beginning: 1/1/01 Ending: 12/31/01

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY1998	FY1999	FY2000	FY2001	FY2002	FY2003	FY2004	FY2005	FY2006
1			$		$	$	$	$	$	$	$	$	$
2	None												
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Care Center of Abingdon # 0036053 Report Period Beginning: 1/1/01 Ending: 12/31/01

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **No**

(2) Are there any dues to nursing home associations included on the cost report? **Yes**
If YES, give association name and amount. **See page 21, Section F**

(3) Did the nursing home make political contributions or payments to a political action organization? **Yes** If YES, have these costs been properly adjusted out of the cost report? **Yes**

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? **No** If YES, what is the capacity? **N/A**

(5) Have you properly capitalized all major repairs and equipment purchases? **Yes**
What was the average life used for new equipment added during this period? **8 yrs**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **1,313** Line **10**

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? **Yes** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **No**
If YES, give effective date of lease. **N/A**

(9) Are you presently operating under a sublease agreement? YES **x** NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO **x** If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. $ **48,180**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? **No** If YES, attach an explanation of the allocation.

SEE ACCOUNTANTS' COMPILATION REPORT

(13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? **Yes**

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? **No** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ **0** Has any meal income been offset against related costs? **Yes** Indicate the amount. $ **6,425**

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **No**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? **No** If YES, please indicate the amount of income earned from such a program during this reporting period. $ **N/A**
c. What percent of all travel expense relates to transportation of nurses and patients? **None**
d. Have vehicle usage logs been maintained? **Yes**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **Yes**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **N/A**
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. $ N/A

(17) Has an audit been performed by an independent certified public accounting firm? **No**
Firm Name: **N/A** The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? **N/A** If no, please explain. **N/A**

(18) Have all costs which do not relate to the provision of long term care been adjusted out out of Schedule V? **Yes**

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of services performed been attached to this cost report? **N/A**
Attach invoices and a summary of services for all architect and appraisal fees.

FACILITY NAME: Care Center of Abingdon YEAR ENDED: 12/31/01

COST REPORT GROUPINGS
DATA INPUT SHEET

Cost Center	Cost Type	Grouping Code	$ Amount
Dietary	Labor	1-1	126,028
Dietary	Supplies	1-2	7,868
Dietary	Other	1-3	6,600
Nursing	Labor	10-1	676,823
Nursing	Supplies	10-2	73,929
Nursing	Other	10-3	2,971
Therapy	Labor	10A-1	0
Therapy	Other	10A-3	63,570
Activities	Labor	11-1	42,830
Activities	Supplies	11-2	944
Activities	Other	11-3	315
SocSerDir	Labor	12-1	29,277
SocSerDir	Other	12-3	330
NurseAideTrng	Labor	13-1	0
NurseAideTrng	Supplies	13-2	0
NurseAideTrng	Other	13-3	0
ProgramTransp	Other	14-3	702
Administrative	Labor	17-1	64,823
Prof. Services	Other	19-3	91,650
FoodPurchase	Supplies	2-2	106,570
Fees,Subs&Promo	Other	20-3	30,628
Clerical&GO	Labor	21-1	16,629
Clerical&GO	Supplies	21-2	11,742
Clerical&GO	Other	21-3	23,100
EmployeeBen	Other	22-3	207,934
Inservice Training	Other	23-3	225
Travel	Other	24-3	637
Seminar	Other	24-3a	1,078
Admin Staff Transp	Other	25-3	1,103
Insurance	Other	26-3	42,716
Bad Debts	Other	27-3	2,202
Lobbying	Other	27-3a	387
Housekeeping	Labor	3-1	56,087
Housekeeping	Supplies	3-2	10,885
Housekeeping	Other	3-3	250
Depreciation	Other	30-3	18,650
Amort of Pre-Op	Other	31-3	0
Interest	Other	32-3	8,809
RealEstateTax	Other	33-3	51,195
Rent-Facility	Other	34-3	275,616
Rent-Equip&Vehicle	Other	35-3	2,411
Amortization	Other	36-3	0
Ancillary	Labor	39-1	0
Ancillary	Other	39-3	2,206
Laundry	Labor	4-1	40,658
Laundry	Supplies	4-2	3,869
Vending	Other	41-3	3
ProvParticFee	Other	42-3	48,180
Utilities	Other	5-3	65,595
Maintenance	Labor	6-1	18,070
Maintenance	Supplies	6-2	9,561
Maintenance	Other	6-3	14,568
MedicalDirector	Other	9-3	12,000

Balance Sheet	Grouping Code	$ Amount
Cash	A1	75,624
Patient Deposits	A2	1,296
Accounts Receivable	A3	313,800
Prepaid Insurance	A6	0
Other Prepaid Exp	A7	0
Related Party Rec'ble	A8	0
Interdivision Receivable	A9	0
Interest Receivable	A9a	0
Long-Term Investments	B12	0
Land	B13	0
Buildings	B14	0
Leasehold Improve	B15	246,955
Equipment	B16	243,850
Accum Depreciation	B17	(293,728)
Deferred Maintenance	B18	0
Org & Pre-Op Costs	B19	0
Accum Amortization	B20	0
Loan Financing Costs	B23a	0
Leasehold Deposit	B23b	0
Total Assets		587,797
Accounts Payable	C26	69,706
A/P-Patient Deposits	C28	1,296
Accrued Salaries	C30	87,369
Accrued Taxes	C31	2,738
AccrRealEstateTax	C32	47,800
Accrued Interest	C33	8,809
Interdivision Payable	C36	405,000
Other Current Liab	C37	65,000
Mortgage Payable	D40	0
Security Deposits	D44	0
Retained Earnings	E1	316,980
Distributions	E13	0
Transfers	E18	0
Total Liab & Equity		1,004,698
Net Income(Loss)		**(416,901)**
Ending RE		**(99,921)**
Gross Revenue	R1	1,810,137
NurseAideTrngReimb	R11	0
Vending	R12	0
Barber & Beauty	R13	2,374
Non-Patient Meals	R14	6,425
Telephone & TV	R15	0
Non-Patient Supplies	R18	0
Contributions	R24	0
Interest	R25	414
Recoveries	R28	0
Durable Med Equip	R28a	855
Gain(loss)-equipment	R28b	0
Outpatient Services	R5	0
Therapy	R6	31,080
Oxygen	R7	4,000
Income Tax (expense)	R42	38
Total Revenue		1,855,323
Total Costs		2,272,224
Net Income(Loss)		**(416,901)**
Input Error (s/b -0-)		**0**

FACILITY NAME: Care Center of Abingdon **YEAR ENDED:** 12/31/01

OTHER INFORMATION DATA INPUT SHEET

Sales Tax			161
(Grouping Code 2-2 a/c # 9850 - Sales Tax)			
Diaper Expense			1,313
(Grouping Code 10-2 a/c # 4115 - Incontinence)			
Prior Year Ending Equity		0	316,980
(page 17, line 47)		var	
Prior Year Accrued Real Estate Tax			43,380
(page 17, line 32)			
Amount of Note - Original			0
(prior year page 9, column 6)			
Accrued Employee Time	**Ending**		60,289
(Grouping Code C30, a/c # 1715)	**Beginning**		55,802
Vehicle Expense			651
(Grouping Code 25-3 a/c # 9305)			
Interdivsion Transfers		0	0
		var	
Shareholder Distributions		0	0
		var	
MEDICARE BEDS	**Ending**		12
CENSUS INFORMATION (beds)	**Beginning**		88
	Ending		88

Beginning Equity Adjustments	
Uncollectible patient accounts	0
Medicare cost report settlements	0
Related party accrued interest income	0
Workers' comp insurance	0
Miscellaneous	0
Illinois replacement tax	0
Net Prior Period Adjustments	0

Tax Return Info			
Meals expenses:	**14-3**		50
(by grouping code)	**23-3**		0
	24-3		115
	24-3a		0
50% tax limitation =	**83**		165
Tax depreciation expense			16,617
Capital Lease Depreciation			68,181
Fines and Penalties			0
Out-of-State Training			0

Real Estate Tax History		
(prior year page 10)	**1995**	47,481
	1996	47,083
	1997	45,022
1999 tax payments	45,525	**1998** 43,373
(per tax bill) var	0	

		SALARY COSTS		**Page 20 Line/Amt**	
676,823	10-1	4000	42,527	1	42,527
0		4005	0	2	0
var		4006	25,994	32	28,220
		4007	537	32	
		4008	6,039	31	6,039
		4010	81,207	3	109,225
		4011	28,018	3	
		4015	107,292	4	121,719
		4016	14,427	4	
		4018	1,689	32	
		4020	278,964	5	369,093
		4021	0	32	
		4022	0	5	
		4023	43,500	5	
		4024	23,686	5	
		4025	22,267	5	
		4026	676	5	
0	10A-1	4050	0	7	0
0		4051	0	8	0
		4052	0	8	
		4055	0	7	
		4056	0	8	
		4060	0	7	
42,830	11-1	2000	20,723	9	20,723
0		2005	22,107	10	22,107
64,823	17-1	8000	47,379	20	47,379
0		8005	17,444	21	17,444
	Total		**784,476**		**784,476**

		CONSULTANT SERVICES			**Pg 20. Ln/Amt**
2,971	10-3	4400	1,440	39	1,440
0		4425	0	46	0
		4455	1,531	37	1,531
63,570	10A-3	4550	2,794	40	37,080
0		4551	30,948	40	
		4552	3,338	40	
		4575	2,503	41	19,304
		4576	16,153	41	
		4577	648	41	
		4600	349	43	7,186
		4601	4,954	43	
		4602	1,883	43	
		4650	0	40	
	Total		**66,541**		**66,541**

CENSUS INFORMATION (days)	
Private Skilled	1,321
Paid Bedhold	9
Non-paid Bedhold	0
Paid Discharge	0
Private Intermediate	3,979
Paid Bedhold	18
Non-paid Bedhold	0
Paid Discharge	0
Private Other	0
Paid Bedhold	0
Paid Discharge	0
Sheltered Care	0
Paid Bedhold	0
Paid Discharge	0
Medicare	1,315
Paid Bedhold	0
Non-paid Bedhold	0
Paid Discharge	0
Medicaid	11,253
Paid Bedhold	6
Non-paid Bedhold	0
Paid Discharge	0
V.A. days	0
Total Days	17,901

CENSUS SUMMARY	
Private Skilled	**1,321**
Private Intermediate	**3,979**
Sheltered Care	**0**
Medicare	**1,315**
Medicaid	**11,253**
V.A.	**0**
Total Patient Days	**17,868**
Bed hold Days	**33**
Total Days	**17,901**
Medicaid Allocation:	
Skilled (1/3)	**3,751**
Intermediate (2/3)	**7,502**
Medicaid Paid Bedhold	**6**

FACILITY NAME: Care Center of Abingdon
ID#: 0036053

BEGINNING: 1/1/01
ENDING: 12/31/01

RELATED PARTIES DATA INPUT SHEET

1	Balance Sheet	Grouping Code	Facility $ Amount	RFMS Mngmnt Amount	Lessor Amount	Consoli-dated Total
	Cash	A1	75,624	81,255	0	156,879
	Patient Deposits	A2	1,296	0	0	1,296
	Accounts Receivable	A3	313,800	425,795	0	739,595
	Prepaid Insurance	A6	0	27,491	0	27,491
	Other Prepaid Exp	A7	0	0	0	0
	Related Party Rec'ble	A8	0	1,574,571	0	1,574,571
	Interdivision Receivable	A9	0	0	0	0
	Interest Receivable	A9a	0	0	0	0
	Long-term Investments	B12	0	104,078	0	104,078
	Land	B13	0	0	3,333	3,333
	Buildings	B14	0	0	1,619,596	1,619,596
	Leasehold Improve	B15	246,955	134,810	101,380	483,145
	Equipment	B16	243,850	622,295	210,235	1,076,380
	Accum Depreciation	B17	(293,728)	(601,776)	(1,057,672)	(1,953,176)
	Deferred Maintenance	B18	0	0	0	0
	Org & Pre-Op Costs	B19	0	0	0	0
	Accum Amortization	B20	0	0	0	0
	Loan Financing Costs	B23a	0	0	0	0
	Leasehold Deposit	B23b	0	0	0	0
	Total Assets		587,797	2,368,519	876,872	3,833,188
	Accounts Payable	C26	69,706	34,290	0	103,996
	A/P-Patient Deposits	C28	1,296	0	0	1,296
	Short-Term Notes Pay	C29	0	0	0	0
	Accrued Salaries	C30	87,369	125,952	0	213,321
	Accrued Taxes	C31	2,738	0	0	2,738
	AccrRealEstateTax	C32	47,800	5,886	0	53,686
	Accrued Interest	C33	8,809	0	0	8,809
	Interdivision Payable	C36	405,000	0	0	405,000
	Other Current Liab	C37	65,000	0	0	65,000
	Mortgage Payable	D40	0	0	0	0
	Patient Deposits	D44	0	0	0	0
	Retained Earnings	E1	316,980	2,202,391	876,872	3,396,243
	Distributions	E13	0	0	0	0
	Transfers	E18	0	0	0	0
	Total Liab & Equity		1,004,698	2,368,519	876,872	4,250,089
	Net Income(Loss)		**(416,901)**	**0**	**0**	**(416,901)**

2		
	Lessor - Interest Expense	0
	Lessor - Loan Fee Amortization	0

FACILITY NAME:	Care Center of Abingdon	**BEGINNING:**	1/1/01
ID #:	0036053	**ENDING:**	12/31/01

ATTACHED SCHEDULE I

VII. RELATED NURSING HOMES

FACILITY NAME	CITY
Care Center of Abingdon	Abingdon
Centralia Manor	Centralia
Jerseyville Manor	Jerseyville
Lawrenceville Manor	Lawrenceville
Leroy Manor	Leroy
Maryville Manor	Maryville
Parkway Manor	Marion
Pekin Manor	Pekin
Pittsfield Manor	Pittsfield
Seminary Manor	Galesburg
Shelbyville Manor	Shelbyville

RECLASSIFICATION ENTRY	Schedule and Line #	Total Per General Ledger (Column 4)	Reclass Increase or (Decrease) (Column 5)	Reclassified Total (Column 6)
(1) To Allocate a % of Vehicle Expenses To Program				
Program Transportation	V-14	702	552	1,254
Other Admin. Staff Transportation	V-25	1,103	(552)	551

SCHEDULE V - LINE 25 - OTHER ADMIN. STAFF TRANSPORTATION

Care Related Vehicle Expenses:	
Fuel and miscellaneous supplies	651
Repairs and maintenance	452
Total vehicle expenses	1,103

FACILITY NAME:	Care Center of Abingdon	**BEGINNING:**	1/1/01
ID #:	0036053	**ENDING:**	12/31/01

ATTACHED SCHEDULE II **Bed Allocation**

FACLITY NAME:	**Care Center of Abingdon**	**BEGINNING:**	**1/1/01**
ID#:	**0036053**	**ENDING:**	**12/31/01**

ATTACHED SCHEDULE III **Allocation of Related Party Administrative Service Costs**

SUMMARY SCHEDULE

(See attached detail schedule)

Sch. V Line #		Salaries	Other	Total
1	Dietary			0
2	Food Purchase			0
3	Housekeeping			0
4	Laundry			0
5	Heat & Other Utilities		176	176
6	Maintenance		253	253
7	Other			0
9	Medical Director			0
10	Nursing & Med Records			0
10A	Therapy			0
11	Activities			0
12	Social Services			0
13	Nurse Aide Training			0
14	Program Transportation			0
15	Other			0
17	Administrative	44,679		44,679
18	Directors Fees			0
19	Professional Services		1,563	1,563
20	Fees, Subs. & Pro.		7	7
21	Clerical & General		3,826	3,826
22	Employee Ben. & P/R		7,115	7,115
23	Inservice Training & Ed.			0
24	Travel & Seminar		2,119	2,119
25	Admin. Staff Transp.		1,733	1,733
26	Insurance		127	127
27	Other			0
30	Depreciation		1,651	1,651
31	Amortization of Pre-Op.			0
32	Interest		82	82
33	Real Estate Taxes		156	156
34	Rent-Facility & Grounds		2,117	2,117
35	Rent-Equip. & Vehicles		355	355
36	Other - Amortization			0
	TOTALS	44,679	21,280	65,959

19	Amount per G/L - administrative services recorded as professional fees	(66,000)
	Net adjustment required	(41)

FACLITY NAME:	**Care Center of Abingdon**	**BEGINNING:**	**1/1/01**
ID#:	**0036053**	**ENDING:**	**12/31/01**

ATTACHED SCHEDULE III **Allocation of Related Party Administrative Service Costs**

DETAIL SCHEDULE

ALLOCATION FACTORS	Total Y-T-D Beds	Facility Y-T-D Beds	Allocation Percentage
ALL FACILITIES	**33,156**	**780**	**2.3525%**
NURSING HOME FACILITIES	**16,128**	**780**	**4.8363%**

	Total Costs Incurred	Non-Allowable Costs	Adjusted Costs	Allocated Costs	Schedule & Line Reference
ALL FACILITIES:					
Salaries - Owner	200,000		200,000	4,705	V-17
Salaries and wages	816,159	49,212	766,947	18,043	V-17
Advertising	317		317	7	V-20
Insurance	5,401		5,401	127	V-26
Payroll taxes & other benefits - Owner	37,441	23,970	13,471	317	V-22
Payroll taxes & other benefits	156,214	10,580	145,634	3,426	V-22
Utilities	8,579	1,089	7,490	176	V-5
Telephone	35,472		35,472	834	V-21
Building rental	90,000		90,000	2,117	V-34
Depreciation	70,200		70,200	1,651	V-30
Interest	3,481		3,481	82	V-32
Legal fees	13,898	6,364	7,534	177	V-19
Accounting fees	92,167	50,765	41,402	974	V-19
Outside management consutants	17,500		17,500	412	V-19
Supplies	100,911		100,911	2,374	V-21
Airplane & vehicle rental	15,098		15,098	355	V-35
Vehile expense	15,156		15,156	357	V-25
Travel reimbursements	38,443	34,103	4,340	102	V-24
Meal expense	15,657	8,137	7,520	177	V-24
Training	4,985	2,350	2,635	62	V-24
Real estate taxes	6,612		6,612	156	V-33
Building & equipment maintenance	10,752		10,752	253	V-6
Other	28,403	28,403	0	0	V-21
Printing	4,030	48	3,982	94	V-21
SUBTOTALS	1,786,876	215,021	1,571,855	36,978	
NURSING HOME FACILITIES:					
Salaries and wages	453,471		453,471	21,931	V-17
Insurance	0		0	0	V-26
Payroll taxes & other benefits	69,718		69,718	3,372	V-22
Telephone	10,835		10,835	524	V-21
Vehicle expense	28,445		28,445	1,376	V-25
Vehicle lease	0		0	0	V-35
Travel reimbursements	21,672		21,672	1,048	V-24
Meal expense	2,792		2,792	135	V-24
Training	12,306		12,306	595	V-24
SUBTOTALS	599,239	0	599,239	28,981	
TOTALS	2,386,115	215,021	2,171,094	65,959	

SUMMARY SCHEDULE

Salaries - Administrative	**44,679**	**V-17**
Heat & Other Utilities	**176**	**V-5**
Maintenance	**253**	**V-6**
Professional Services	**1,563**	**V-19**
Fees, Subscriptions & Promotion	**7**	**V-20**
Clerical & General Office Exp.	**3,826**	**V-21**
Employee Benefits & P/R Taxes	**7,115**	**V-22**
Travel & Seminar	**2,119**	**V-24**
Other Admin. Staff Transp.	**1,733**	**V-25**
Insurance	**127**	**V-26**
Depreciation	**1,651**	**V-30**
Interest	**82**	**V-32**
Real Estate Taxes	**156**	**V-33**
Rent - Facility	**2,117**	**V-34**
Rent - Equipment & Vehicles	**355**	**V-35**
	21,280	
	65,959	

FACILITY NAME:	Care Center of Abingdon	**BEGINNING:**	1/1/01
ID#:	0036053	**ENDING:**	12/31/01

ATTACHED SCHEDULE IV **Related Party Cost Adjustment**
Facility Rent

Cost to Related Party Lessor:			
Depreciation (Reported on Sch. XI)	**68,181**		**V-30**
Interest	**0**		**V-32**
Loan Fee Amortization	**0**		**V-36**
Total lessor cost		**68,181**	
Cost Per General Ledger - Facility Rent		**275,616**	**V-34**
Cost Adjustment Required		**(207,435)**	

FACILITY NAME:	**Care Center of Abingdon**	**BEGINNING:**	**1/1/01**
ID #:	**0036053**	**ENDING:**	**12/31/01**

ATTACHED SCHEDULE V

PAGE 19, XVII. INCOME STATEMENT

Federal Income Tax Return Reconciliation:

Income (loss) before income taxes (Line 41)		**(416,939)**
Nondeductible expenses:		
50% meal exclusion	**83**	
Fines and penalties	**0**	
Lobbying expenses	**387**	
		470
Timing differences:		
Depreciation expense - tax basis	**(16,617)**	
Depreciation expense - book basis	**18,650**	
Accrued vacation exp. - prior year	**(55,802)**	
Accrued vacation exp. - current year	**60,289**	
		6,520
Taxable income (loss)		**(409,950)**

FACILITY NAME: Care Center of Abingdon BEGINNING: 1/1/01

ID#: 0036053 ENDING: 12/31/01

ATTACHED SCHEDULE VI

SCHEDULE V - COST CENTER EXPENSES

LINE 27 - OTHER:

Bad Debts	2,202
Lobbying	387
Total	2,589

ATTACHED SCHEDULE VII

SCHEDULE VI - ADJUSTMENT DETAIL

LINE 29 - OTHER:

Out-of-state Training	V-23	0
Lobbying	V-27	387
Activity fund income	V-11	0
Total		387

ATTACHED SCHEDULE VIII

Page 17, XV. BALANCE SHEET

	Operating	After Consolidated
Line 9, Other Current Assets:		
Interdivision Receivable	0	0
Interest Receivable	0	0
Total	0	0

ATTACHED SCHEDULE IX

Page 18, XVI. STATEMENT OF CHANGES IN EQUITY

Line 4, Restatements:

Uncollectible patient accounts	0
Medicare cost report settlements	0
Related party accrued interest income	0
Workers' comp insurance	0
Miscellaneous	0
Illinois replacement tax	0
Total	0

Restatements are year end adjustments which were made subsequent to the preparation of the Medicaid cost report for the prior year. The equity balance at the beginning of the year, restated by the above adjustments, agrees with the financial statements.

FACILITY NAME:	Care Center of Abingdon	**BEGINNING:**	1/1/01
ID#:	0036053	**ENDING:**	12/31/01